ON MY OWN

UNDERSTANDING RESILIENCE OF COUNSELLORS WORKING PUBLICLY IN RURAL AND REMOTE NEW SOUTH WALES

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Abstract

Aim: Counsellors working as sole practitioners in rural and remote towns in New South Wales (NSW) experience unique challenges. The aim of this study was to explore the resilience experiences of this workforce with a view to provide improved support and potential retention of workers in these roles.

Methods: This qualitative study used semi-structured individual interviews supported by an Appreciative Inquiry (AI) methodology. AI was chosen for its ability to focus on strengths and identify ways to provide further support. The interview transcripts were thematically analysed by two coders, to identify themes.

Participants: Five counsellors and two social work students working/placed in rural and remote towns in the Western NSW Local Health District.

Findings: Participants in the study identified challenges in relation to community interaction and professional isolation, these challenges were consistent with those identified in the literature. Participants were able to demonstrate resilience in relation to their unique situation as evidenced by three themes: i) building connection and relationships within their community and with other professionals, ii) skills in self-care and iii) acknowledging their role in the client's development of resilience. When further explored, the third theme introduced the concepts of compassion satisfaction and vicarious resilience of which the participants had limited understanding.

Conclusion/Implication: Counsellors working as sole practitioners were skilled in developing resilience. The challenge for health services is to facilitate ongoing professional connections. Future directions for the workforce revolve around enhanced understanding and application of the concepts of vicarious resilience and compassion satisfaction.

Keywords: rural, remote, retention, resilience, compassion satisfaction, vicarious resilience

Executive Summary

The aim of this study was to explore how counsellors working for New South Wales (NSW) Health, as sole practitioners in rural and remote towns, had incorporated resilience into their practice. Resilience is the 'ability to adapt to change or manage adverse life experiences' (Burnett & Wahl 2015 p. 319). Poor resilience is a contributing factor in staff turnover (Matheson et al 2016). This is important as it is well documented that recruitment and retention of health workers in rural and remote areas is problematic (Bourke t al 2010).

This qualitative study was conducted using semi-structured interviews of five sole practitioner counsellors and two students. Participants had all experienced working in rural or remote areas of Western New South Wales Local Area Health District (WNSWLHD). For the purpose of this study rural and remote was defined by the Australia Government Department of Health, Rural, Remote and Metropolitan Area (RRMA) classification. Although Drug and Alcohol, and Mental Health counsellors were also invited to participate, the five counsellors who took part were all members of the Prevention and Response to Violence, Abuse and Neglect (PARVAN) team, working as Sexual Assault, Child Protection, and Domestic Violence counsellors.

Summary of Findings

The participants identified challenges of working and living in rural and remote towns. The challenges were associated with professional isolation and community interaction and were consistent with those identified in the literature. The participants were able to demonstrate resilience in the strategies they had employed to meet these challenges. These were identified in three themes: i) building connection and relationships within their community and with other professionals, ii) skills in self-care, and iii) acknowledging their role in the client's development of resilience. Building professional and community connections mitigated the challenge of professional isolation. The participants were intentional in their self-care strategies. The strategies identified by the participants expanded on the expected self-care activities to include taking part in bigger picture activities. In acknowledging their role in the client's development of resilience, the concepts compassion satisfaction and vicarious resilience were explored. Although the participants were able to talk about experiences where they developed a sense of wellbeing from being part of their client's development of resilience, they were not familiar with the terms compassion satisfaction and vicarious resilience that describe this phenomenon. A reason for this is that the terms are not clearly defined in the literature and this study contributes to the ongoing discussion around a more consistent definition of these concepts.

The participants indicated that they valued the support from management, however they also made suggestions around how this could be improved. Management needs to continue to support access to face-to-face interactions within their PARVAN teams through professional development opportunities. Management also needs to understand the specific needs of the PARVAN counsellors. Encouraging the counsellors to spend time developing connections with other workers in their workplace and taking part in bigger picture opportunities also need to be supported by management. Access to providers of supervision that understand both the challenges of rural and remote work and their specific professional roles is important. It is also important to include the discussion around compassion satisfaction in supervision.

As resilience has an impact on retention, this study has relevance in relation to the NSW Rural Health Plan: Towards 2012, and the Health Professionals Workforce Plan (2012-2022 [Revised Plan]). The information around resilience is also relevant to health workers outside of the traditional counselling roles who potentially are exposed to vicarious trauma. For example, health workers engaging with those who have

experienced domestic violence. This was identified in the NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026, Strategic Direction Three, of the Priority 3.4: Support the workforce and build resilience. (New South Wales Ministry of Health 2021, P44).

Recommendations

1. Western NSW Local Area Health District (WNSWLHD) Senior Manager Child Protection, Domestic Violence and Family Violence, and Community Health Managers support practitioners to develop professional connections both within their community and within their workplace. This includes taking part in bigger picture activities such as working parties, projects, supervising students and face to face professional development opportunities.
2. Community Health Managers to have a better understanding of the role of PARVAN counsellors and their unique professional development needs. Approval to attend professional development opportunities needs to be consistent across sites.
3. Counsellors working in remote and rural areas need to have access to providers of professional supervision who understand both the specific role of the counsellor and the challenges of rural and remote work.
4. Current PARVAN review of professional supervision to include looking at how compassion satisfaction and vicarious trauma can be included in supervision.
5. The findings from this study be used to inform implementation of worker recruitment and retention policies such as NSW Rural Health Plan: Towards 2012, and the Health Professionals Workforce Plan (2012-2022 Revised Plan).
6. The findings from this study be used to contribute to the implementation of supporting workers to develop vicarious resilience as per NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026, Strategic Direction Three, priority 3.4: Support the workforce and build resilience.

Introduction

This study was borne out the personal experiences of the writer, who four years ago started in the role of Child Protection Counsellor in Bourke, a remote town in North-western NSW. The writer was interested to find out how other counsellors in similar circumstances had developed resilience in the face of the challenges of being a sole practitioner in a rural/remote town. Child Protection Counsellors, along with those in other counselling roles including Sexual Assault, Domestic Violence, and some Mental Health, and Drug and Alcohol roles are sole practitioners because they are required to exercise independent professional judgement (The NSW Health Service Health Professionals [State] Award 2018). Although these counsellors are part of broader teams spread across the WNSWLHD, they are usually the only ones in their area of expertise employed at their work site. The focus of the study was on sole practitioner counsellors employed in rural and remote areas, based on the assumption that their experiences would be different to those based in regional centres and metropolitan areas. Due to the challenges intrinsic to rural and remote work, these roles are difficult to recruit to and retention is also problematic.

Background

Challenges of working in rural and remote areas

The shortage of health professionals in rural and remote areas is problematic worldwide (Keane, Lincoln & Smith 2012,). It is a particular problem in Australia as a third of the population in rural and remote areas spread across a large geographical expanse (Lockie & Bourke 2001, cited by Bourke, et al 2010). Recruitment and retention of experienced health professionals has been attributed as the main reason for the shortage (Humphreys et al 2009). This shortage is concerning as it impacts on patient health care (Buykx, et al 2010). Ongoing recruitment is also expensive for Health organisations (Buykx, et al. 2010). Recruitment and retention problems have been attributed to the unique challenges both professional and personal that health workers in rural and remote areas encounter (Keane, et al 2008). Some of these challenges include; harsh climatic conditions and geographical isolation, limited access to services, poor infrastructure, and community disadvantage (Nickson, et al 2016). There are also the personal challenges for the workers of living and working in small communities such as the overlapping of personal and professional life (Nickson, et al 2016).

Keane, Lincoln, & Smith (2012) conducted focus groups with rural allied health workers through which the following challenges, referred to as push factors, were identified:

> *..lack of employment opportunities for spouses; perceived inadequate quality of secondary schools; age related issues (retirement, desire for younger peer social interaction, and intention to travel); limited opportunity for career advancement; unmanageable workloads; and inadequate access to CDP (continuing professional development)* (Keane, et al 2012 p1).

Bourke, et al (2010) argued that the literature on the experience of living and working in rural and remote areas focuses on the challenges, and that the opportunities also need to be explored. The participants in the Keane et al study (2012) identified the following benefits of working rural and remotely, referred to as pull factors:

> *…attraction to the rural lifestyle; married or having family in the area; low cost of living; rural origin; personal engagement in the community; advanced work roles; a broad variety of clinical work; and making a difference (*Keane et al 2012 p.1).

While the challenges of recruitment and retention of health workers to rural and remote areas is well represented in the literature, the focus tends to be on recruitment rather than retention (Humphreys, et al 2009). Rural recruitment and retention research have also focused on workplace conditions and career advancement opportunities with less focus on social and personal factors (Cosgrave et al 2018).

Research that looks at the factors that contribute to the retention of allied health workers in rural or remote positions is limited (Cosgrave et al 2018) as the focus tends to be on medical professionals (Battye, et al 2019, Bourke, et al 2010). It is important for allied health workers to be included in the research as rural recruitment and retention is just as problematic for these workers as it is for the medical professions (Cosgrave et al 2018). It is possibly even more important, as evidence indicates that allied health professionals have double the incidents of leaving their rural or remote positions than medical practitioners (Campbell, et al 2021 cited by Cosgrave et al 2018).

Cosgrave et al (2018) noted that it was also important to include allied health workers in research about rural retention as they are potentially exposed to high stress due to the nature of their work. Cosgrave et al (2018) argued that understanding the lived experiences of these workers help provide an understanding of how these workers can be retained. Gaining an understanding of both the push and pull factors around people's decisions to remain working rural and remotely is important (Keane, et al 2012). An understanding of both the professional and personal experiences of working in rural and remote areas is important, as both factors contribute to burnout (Nickson, et al 2016). For this reason an understanding of how these workers have developed resilience is helpful in addresses issues around rentention.

Resilience

Poor resilience contributes to high staff turnover (Matheson et al 2016). Resilience is the 'ability to adapt to change or manage adverse life experiences' (Burnett & Wahl 2015 p. 319). Matheson et al's (2016) study of health professionals found that resilience helped them to cope with the adversity that they experience as part of their work. Counsellors are at high risk of experiencing negative impacts because of working with people who experienced trauma (Stamm 2010). Figley (1995) referred to this as the 'cost of caring'. Several terms are used in the literature to refer this concept including compassion fatigue, secondary trauma, vicarious trauma, and burnout (Stamm 2010). A study of welfare workers living in rural areas found that they are more likely to experience compassion fatigue than those living in urban areas (Sprang, Craig & Clark's 2011). Looking at how those who are able to demonstrate resilience within the context of exposure to these negative impacts is a helpful way to gain a greater understanding of resilience (Matheson et al 2016).

Rationale

This study bridges some of the gaps in the literature. While the challenges of working and living rural and remotely has been well documented, there is limited research on the impacts of these challenges in relation to resilience. Research focused on allied health workers is also limited (Battye, et al, 2019). Counsellors working as sole practitioners in rural and remote towns in Western NSW, were chosen as the focus for this study as they are exposed to both the challenges associated with rural and remote work interwoven with the potential for vicarious trauma.

Study Aim

The aim of this study was to explore the resilience experiences of sole practitioner counsellors with a view to provide improved support and potential retention. A further aim was to make these findings applicable to other allied health workers in similar circumstances. This is important as recruitment and retention of allied health workers in rural and remote areas is problematic.

The aims of the study include;

1. Identify the strategies that the participants have developed to build resilience within the context of working and living in rural and remote areas.
2. Gain an understanding of the role that vicarious resilience/compassion satisfaction has played in the building of overall resilience.
3. Identify resilience strategies that could be transferable to other allied health professionals working within a similar context.
4. Identify supportive strategies that NSW Health can consider to encourage retention within these roles.

Method

Research team

The research team for this study comprised of the principal investigator (PI), who is also the writer of this paper, and two associate investigators (TW & KD). All the investigators contributed to the study design, with the PI taking the primary role in the recruitment and interviewing of the participants. All stages of the study were completed under the supervision of TW and KD. The PI has a Masters in Social Work and is a candidate of the NSW Health Rural Research Capacity Building Program (RRCBP). Both associate investigators (TW & KD) have extensive qualitative research experience and work across health services and academic settings.

Methodological orientation and theoretical framework

This study used a qualitative research design based on Appreciative Inquiry (AI). AI is a derivation of phenomenology methodology, which aims to describe the meaning and significance of human experiences (Tong et al 2007). AI comes from a position of focusing on positive experiences rather than problems and provides a framework for implementing organisational change (Scala & Costa 2014). It uses four components: discovery, dream, design, and destiny. Discovery of what behaviours are working in the present, dream of what behaviours could be encouraged, design for future planning for change, and destiny the empowerment of workers to bring about the change (Scala & Costa 2014). This study focused on the discovery and dream components to provide recommendations with the aim of informing future design and destiny components. The positive focus of AI suited this study given that most of the participants knew the PI. This was intended to protect against disclosures of adverse experiences that potentially may have resulted in the PI having to breach confidentiality to ensure safety. With a small study population and sample size, using AI also protected the participants from having to disclose adverse experiences to a peer and the potential of being identified through these negative experiences. The dream component of AI aligns with the study aim of providing useful recommendations to inform practice change.

Ethics Approval

Ethics approval for this study was granted by the NSW Health Greater Western Human Research Ethics Committee, on the 2/4/20 application number 2020/ETH00140 and site-specific application number 2020/STE00223 for Western New South Wales Local Health District dated 2/04/2020.

Participant Selection

Sampling: Purposive sampling was used with 19 people deemed to meet the criteria and invited to take part in the study. The target study population were sole practitioners employed in counselling roles by the WNSWLDH and working in rural and remote areas of NSW. The potential participants were in the following roles: Child Protection, Drug and Alcohol, Domestic Violence, Sexual Assault, and Mental Health. For this research project the Australia Government Department of Health, Rural, Remote and Metropolitan Area Classification (RRMA) was used. The RRMA allocates areas of Australia into seven categories from "Capital city" code 1 through to "Other remote area" code 7 based on a combination of straight-line distance from urban centres of various sizes and population density. The study population was based in areas with a code of 5-7. The study focused on those working in WNSWLDH as this was the only health district that had workers living and working in areas that met this classification.

Recruitment: A non-direct recruitment approach was used to mitigate any risk of coercion or perceived coercion relating to the PI's level of involvement with the potential participants. The potential participants were identified through their roles and were emailed an invitation to participate in the research by the WNSWLHD Manager Child Protection Strategies. Email addresses were sourced from the NSW Health Outlook global email address list. The email included: the Participant Information Sheet, Participant Consent forms, and a copy of the semi-structured interview questions. Participants consented by emailing the completed consent forms directly to the PI. A reminder email was sent to the potential participants 30 days after the first email. The study and requests for participants was also discussed in forums such as the WNSWLHD social work annual meeting. The PI did not approach any participants directly until their consent forms had been received.

Sample size: Of the 19 people who were identified as eligible and invited to take part in the research seven (37%) consented to participate. The small sample size was still considered relevant for a qualitative research design (Peters 2010) and was expected due to the size of the study population.

Non-participation: While no one directly refused to take part, 12 of the invited participants did not respond to the invitation email. No participant dropped out once they had agreed to take part in the interview.

Reflexivity

As stated previously the PI is a Child Protection Counsellor and therefore a peer of the participants. For this reason, reflexivity was an integral part of the methodology of this study. Reflexivity involves the awareness of bias and assumptions that may be present due to pre-existing relationships and the impact that this may have on the outcome of the research (Peters 2010). To address potential bias, the PI's relationship with the participants, and assumptions and personal interests in the research topic is acknowledged (Tong et al 2007). The study aims and objectives were developed from the PI's personal experience. The PI also had a professional relationship with five of the participants prior to conducting

the study. Two of the participants are also Child Protection Counsellors and therefore are in the same team as the PI. One of the participants was a social work student supervised by the PI at the time of the interview. PI is female as were all the participants. The participants were informed about the reasons for doing the research in the participants' information package however some knew about the research previously through presentations at team meetings. They were informed that the research was being conducted through the RRCBP and therefore supported by NSW Health. The fact that the PI is a Child Protection Counsellor, and therefore part of the participant cohort was declared during the ethics application. Bias and assumptions were reflected through journaling, discussing rigour in RRCBP workshops, and weekly meetings between the PI and TW. It was also addressed through shared coding and analysis with all the study investigators.

Data collection

Interview questions: Data were collected from individual in-depth semi-structured interviews with participants. Each interview consisted of six primary questions that aimed to elicit free responses (see appendix 2 for the primary questions). Probing and prompting questions were used if more detail or clarification was required. The interview questions were based on those used in the Professional Quality of Life Scale (PROQOL) version 5 (Stamm 2010). The Professional Quality of Life Scale incorporates two aspects, the positive focused compassion satisfaction, and the negative focused compassion fatigue (Stamm 2010). ProQOL is the "most commonly used measure of the positive and negative effects of working with people who have experienced stressful events" (Stamm 2010 p. 12). The interview questions were practiced with two students (one Occupation Therapy and one Nursing), to estimate how long the interviews would take and to check face validity. The participants in the study were provided with a copy of the primary questions before the interview so that they could consider their responses. Most of the interviews went for about an hour with one going for 45 minutes.

Setting: The interviews were conducted in the workplace counselling rooms either face to face or via Zoom. There was one exception to this as one interview was conducted in a function room used for group supervision. This was a private setting that allowed for confidentiality and was chosen for convenience. No one else was present for any of the interviews.

Recording: All the interviews were digitally recorded and the audio only record was transcribed verbatim by a transcribing service. Two interviews were conducted face to face and were recorded by a digital recorder, the rest were recorded using the secure recording function in the Zoom program. The interviews were conducted either face to face or using Zoom so that the PI could assess from the participants body language if any of the questions were causing distress. There was no indication of distress during the interviews or at the conclusion, with most participants commenting that they enjoyed the experience. Participants were asked if they wanted a copy of their transcripts to check, only one participant requested a written copy. The recordings were sent for transcription as each interview was completed. This allowed for the transcripts to be reviewed to ensure that the questions were covering the aims of the study and to progressively assess for data saturation.

Data saturation: The interview transcripts were progressively reviewed and reflected on through regular meetings between the PI and associate investigator TW. Once the seventh and final interview was reviewed it was decided that no new data were being generated and therefore data saturation had been achieved (Braun & Clarke 2006).

Data analysis

The primary data analysis was conducted by the PI, and associate investigator, TW. The results were reviewed by the second associate investigator, KD, for rigor and to mitigate against any bias (Peters 2010). The data were analysed using an inductive thematic approach, which involves looking for themes as presented in the data rather than being influenced by any pre-existing theoretical framework (Braun & Clarke 2006).

The original plan was for the data analysis to take place with both the PI and TW in the same room and to identify themes using coloured "post-it notes". However, at the time that the data analysis took place, the PI had moved to another town and meeting face to face was no longer practical. This resulted in a review of the planned data analysis methodology. TW and the PI analysed the data separately, meeting regularly via video conferencing to compare outcomes. These outcomes were then discussed with KD for feedback. While there was consistency amongst the investigators there were also areas where interpretation of the data required discussion, which helped with consolidation of the findings.

The coding of the data was completed manually in four stages. The first stage was the familiarisation of the information collected. This consisted of reading through hard copies of each transcribed interview several times. The second stage involved identifying key ideas and colour coding them. Printed transcripts were coloured using different coloured highlighters to identify comments of the participants that related to key words or ideas. The following code was used; 'connections' - highlighted in orange, 'challenges' - highlighted in blue, 'self-care' - highlighted in yellow, 'vicarious resilience and compassion satisfaction' - highlighted in pink, and 'suggestions for how the health system could help' -highlighted in green. The third phase consisted of completing a mind-map for each coded idea to ensure that all aspects of the participants' comments were considered and to identify commonality amongst the data. Mind mapping was used to organise information using a diagram of circles and lines (Cambridge Dictionary Online). It consists of a central concept with subheadings of related themes branching off from this central concept, these branches can then be further subdivided into additional branches (Tattersall, et al 2007). For this study the mind map was created manually using paper and coloured markers. The fourth stage consisted of forming the coded concepts into themes. This involved using the mind map to track connections with similar ideas, to reduce this down to the three themes.

Findings

Participants

Two of the participants were students, two Sexual Assault counsellors, two Child Protection Counsellors and one worked in a Domestic Violence role. Apart from the students all the participants are part of the Prevention and Response to Violence, Abuse and Neglect (PARVAN) team. Although Drug and Alcohol and Mental Health counsellors were also invited to participate none responded. The qualifications of the participants included Bachelor of Health Science, Master of Social Work student, Bachelor Social Work, and Master of Psychology. Four of the participants had two or more years' experience in their roles. All the participants who took part in the study were female. (See Appendix 1 for more detailed demographics).

Themes

Three themes were identified from the interviews: i) building connection and relationships within their community and with other professionals, ii) skills in self-care and, iii) acknowledging their role in the client's development of resilience. When further explored, the third theme introduced the concepts of compassion satisfaction and vicarious resilience of which the participants had limited understanding.

Theme 1: Building Connections

Building connections both within the community and professionally were expressed by the participants as an important part of building resilience and an integral component of self-care. The importance of connections in helping build resilience is well documented in the literature (Figley 1995, Sprang, et al 2011). This theme was divided into two sub-themes, community connections and professional connections.

Community connections

All the participants in this study expressed the value of having connections within their communities and the support that this provided both personally and professionally.

> *..because it's connections I've built over time that I probably maintained, which is something that you do when you are isolated in smaller communities you rely on connections you've built over time.* (Participant 1).

The participants generally found small towns welcoming which assisted with building connections. They appreciated being introduced by community members to the community.

> *… feel like in smaller communities that people kind of go out of their way to introduce you to other people* (P7).

This is consistent with a study conducted by Hegney et al (2015) of nurses working in rural and remote areas. The study found that these nurses had lower levels of secondary stress than those in metropolitan areas and they attributed this to the access to social support networks. Building connections within a community is also an indicator of a worker's intention to stay in the town (Cosgrave et al 2018). While forming connections is important for personal wellbeing (Figley 1995), being connected to a small community also has its challenges. Participants talked about the impact of their high visibility in the community on both their professional and private life. This resulted in a sense of always being on the job. For example, participants talked about being asked for expert advice from family and friends while in social settings. This experience is consistent with other studies, who also reported the blurring of work-life boundaries (Keane, et al 2012, Burgard, 2013). While building connections within the community is an act of self-care, it needs to be balanced with another act of self-care maintaining personal boundaries. There are also associated ethical dilemmas including dual relationships and confidentiality.

Dual relationships refers to the potential of relationships developing outside of the client- therapist relationship and the impact of confidentiality and maintaining professional boundaries (Burgard 2013). It is recognised that dual relationships are unavoidable in small rural communities (AASW Code of Ethics 2020). While the ethical focus on dual relationships is primarily with the view to protect the client, dual relationships can also have an impact on the therapist (Burgard 2013). While two of the participants lived and worked in different towns, the rest of the participants lived and worked in the same towns thus increasing the opportunities for dual relationships. Most participants recognised that they did what they

could to separate their private life from their professional however they acknowledge that this was not always possible.

> *…the smallness of the town… and the fact that you bump into your clients everywhere you go, so I think that that's probably the most challenging … I've got one client at the moment who my child plays with at school, like so that's kind of a bit awkward* (P2).

While the participants identified dual relationships as a challenge, they also felt that they had develop strategies to maintaining boundaries and that this was an important part of self-care. They talked about how they set clear boundaries for themselves and developed strategies around meeting their clients in the community.

> *I did start …my introductions when I met new clients with explaining our confidentiality and privacy and, mandatory reporting responsibilities but I would…say when I run into you in Woollies...I'll follow your lead, if you say hi ..I'm very happy to say hi and I'll probably keep going, because what we talk about in here needs to stay in a private and confidential space* (P3).

Confidentiality was not referred to explicitly by the participants, however they spoke about concepts relating to confidentiality that they found challenging. For example, one participant talked about feeling responsible about holding a client's information and protecting them from false rumours.

> *… also carrying some of the information about people's lives and having to hold that when you hear other people's views or other people talk about things and not really having a sense of what's going on for those people, I think that's challenging* (P1).

Linked to this is the fact that they often know information about the client before they come to counselling.

> *..just knowing a lot of background informally of people within the community and having to kind of separate…well I've heard this rumour about this person but I'm actually …not going to listen to that rumour…I'm just going to take …what's in front of me now.* (P7)

Keeping the confidentiality of the client being involved with the service when they meet outside of the counselling space is difficult. As with dual relationships, most participants took their client's leads about meeting them in public spaces outside of the therapy space.

> *… it's up to them if they acknowledge me outside of work, if they ignore me, I won't take it personally. If they acknowledge me, I'll acknowledge them back.* (P4)

One participant talked about the challenge of maintaining confidentiality in the community alongside also letting people know that that there is a service available.

> *Yeah see I struggle with that in the sense of having to pick people up. I sort of I want the community to know that I'm here, but I also don't want them to know what I do because I am like plain clothes, but it is widely known this is my job and I go to pick someone up.* (P4)

Rural and remote workers may be reluctant to talk about their work with colleagues, friends, and family for fear of unintentionally breaching confidentiality (Helbok et al 2006 cited by Burgard 2013). Therefor confidentiality also has the potential to contribute to the sense of professional isolation.

Professional connections

Participants in the study expressed a sense of professional isolation due to two main reasons. The first reason was due to their unique role as a sole practitioner counsellor. The second reason was the impact of physical distance, which included access to their professional teams and potential professional development opportunities. The participants talked about building professional connection as a strategy that they had developed to mitigate professional isolation. Participants sought out connections with workers in similar roles both within and outside of NSW Health to help reduce the sense of professional isolation. Developing these relationships was intentional and participants saw this as an important part of self-care.

> *… it takes effort too to do that, I mean effort to initiate those relationships…Build connections, connections in the community. ..some of the work that I've done out in the smaller communities, outreach, building relationships with local services, like the local services on the ground has been wonderful for me, having somewhere to go between sessions.* (P1)

> *…our kids go to school together and so like I've met the OT through playgroup and a psychologist because our kids play soccer together and um, so you do get that social interaction with other professionals in the area … which I think does make those professional connections better*. (P2)

Professional connections included forming connections within the workplace with workers in different roles.

> *…and I've certainly built connections with local people in my local team as in where I'm located as well…not a formed group but we bounce ideas off one another… I think about the benefits of actually those connections and the relationships and sharing ideas and information, reinforcing one another in the work you do.* (P1)

Just as with building connections within the community, building professional connections had positive and negative aspects. While professional connections were important and a form of support, there was also the sense that it highlighted the uniqueness of their roles. Participants spoke about the fact that most of the people that they interacted with daily did not understand their role. This produced a limitation to developing a sense of a shared experience.

> *…but then also I found in Community Health say... as a lone social worker there often weren't other colleagues that had an in depth understanding of the kind of work that we are doing… So you could talk to the dietician and you might even, um, have a shared client, but the things that you're talking about are…are vastly different….* (P3)

Most of the participants had two managers, the Community Health Manager who provided the direct management and their specialist managers who was off site. It is important that those providing direct management understand the challenges of the role and help the worker to feel valued as this contributes to a sense of professional satisfaction (Cosgrove et al 2018). One participant described how there is not always consistency in the support provided by the Community Health Manager, primarily because they did not understand the specific needs of the worker.

> *…but we've got the issue of the local management versus the CP (Child Protection) management. That's made a huge difference to me in terms of having a local manager who's consistent and supportive…but also it makes a difference to staying in the role too and how you feel and satisfaction. But also trust too, because my local manager recognises that I'm employed in the specialist role and she knows that I do my work, so it's like a check in ...I guess it's respectful...I've*

had colleagues where I've felt bad because they haven't had, there's been inconsistencies with that and so I've felt. 'oh gosh, that's not, I feel terrible. That's not fair that you can't do that and I can' (P1).

While the participants all valued making professional connections there was a sense that they felt guilty about taking time out from their work to do this. It is important that management support workers to build support networks as this is an important factor in self-care (Sprang, et al 2011).

Because I think you really do need to have personal relationships with your team members as well as the professional ones, because it just – it means that you get to know and trust who you're actually working with. (P2)

All the participants expressed that they felt supported by their specialist managers,

I feel like I would struggle a lot more if I didn't have the good support…from my specialist management. …it's sad that it took years and years of being in Health to actually feel that about management, but I think for sole practitioners, I think that it is like beyond important to not fear having to ask your manager for something or to have a tough conversation with them. (P4)

Participants talked about the impact that distance had on their work and the resulting sense of professional isolation. They talked about the challenges of being part of a geographically diverse team and talked about the importance of allowing for travel to face-to-face professional development opportunities. Face to face interaction with their team helped to build personal connection and relationships.

B*ecause I think you really do need to have personal relationships with your team members as well as the professional ones, because it just-it means that you get to know and trust who you're actually working with.* (P2)

However, there was also the sense that the participants took responsibility to maintain those connections even if they were physically distant.

I think it is very much having to adjust to the challenges of distance and isolation and the limitations of service availability… And I suppose distance to access support for yourself or for your own development too is another challenge and prioritizing that too in amongst everything else (P1).

Lack of services was another contributing factor to the sense of professional isolation identified by the participants. Participants expressed a sense that they were a "'jack of all trades'" as they covered the short fall. They also expressed a concern that this has an impact of the client's ability to choose a service that best meets their needs.

I used to say to people I'm the jack of all trades and master of none…. honestly when I came to the country, I thought oh a small town…that will be the easiest job that I've ever had. This is the hardest job that I have ever had because of that …expectation that you have to cover everything and anything (P3).

There were also concerns expressed in relation to the impact that distance has on the clients either when they travel to the service or the service travels to them. Providing outreach to another town is challenging because it can be difficult to know the other services in the town. The logistics of clients traveling to another town for a service can result in the client not accessing a service.

From an Appreciative Inquiry perspective, the discovery aspect was the identification of the challanges, and the dream aspect was the suggestions of how they could be supported to address these challenges. The participants' responses indicate that building professional and community connections is important and needs to be seen as a valuable part of their role. One participant spoke about how connecting with others in similar roles in the workplace was actively organised by their local manager. Participants also identified the importance of site visits especially for new workers, and other face to face professional development opportunities. These opportunities need to be supported by management including explicit permission to spend time on building professional connections.

> *…that chance to actually go around and meet people and meet your colleagues and have time to do that probably was something that I know helped me feel well, feel like I'd had a great introduction and I could pick up the phone because I knew and I could… I felt like I had an opportunity to meet people rather than just be given a name and say, 'well ring them if you've got a question (P1).*

> *The fact that we're able and supported to do training together …has made those connections within the team, our broader team, and dispersed team stronger* (P2).

The participants also suggested that professional isolation could be mitigated through greater education of other health workers about their specific roles, as often these counselling roles are less clear to their follow health worker than other health roles. Other suggestions included weekly huddle/check ins and buddy systems for new workers, a greater focus on recruitment and more funding for relevant roles

> *…definitely more funding for more positions, especially out in these areas um because if there's not many social workers out here, not only does the community suffer because there's not that service, there's then not support for the very few that are out here (P5).*

> *Recruiting staff is another thing and supporting staff to stay in those jobs. And I see staff feeling valued and you do that by providing them with support but also training and opportunities and that's always a challenge (P1).*

Theme 2. Self-care.

The second theme self-care was identified as important to the participants because of the challenges of working and living in rural and remote areas.

> *The level of adversity and the degree of mental health stress and um complexity of the problems that I've seen in the rural role…are far greater than any of the issues I've had to support individuals and families within in city and in metro settings (P3).*

Just like building connections these other types of self-care were intentional and planed.

> *…on the personal level, making sure that I do something outside and have clear plans about my own self-care is really important'* (P1).

> *…Keeping a balance outside of work and doing really um for me its creative or grounding things helps me be more resilient. And I know if I haven't been doing them that's when I feel very tired and like I've got nothing left* (P3).

Participants were able to identity things that were expected self-care strategies such as taking baths, meditation, exercise, ensuring that they took part in social activities, and "veging out". One participant found that travel time provided a chance to think and debrief. Another participant identified that if there was something on their mind they would; "… go for a walk. *I would tell a tree*" (P4).

Bigger Picture activities. The participants were also able to identify less obvious strategies for self-care such as taking part in bigger picture activities and challenges outside of their direct role, through creating professional networks, involvement in working parties, connecting with other services, supervising students', and running groups with other services.

> *I've been involved in some things that are external to health in terms of professional development too, just local mental health support professional groups and that sort of stuff…..The other thing that I've found. I suppose it makes you feel less isolated and that you're also contributing, supervising a student* (P1).

> *…another thing my supervisor had always said, make sure you connect yourself to like a national movement or some other big picture thing where you feel like you can make a difference, because client work alone isn't enough* (P3).

Professional Supervision was identified by the participants as an important element of self-care. The Australian Association of Social Workers -Supervision Standards 2014 defines professional supervision as a process involving at least two people, one of whom is a supervisor, where professional review, reflection and critique takes place (Davys & Beddoe, 2010: p21 cited by AASW Supervision Standards 2014 p2). In the context of the participants supervision is both on-one and within a group setting.

> *I also found clinical supervision … critical because that person became my go to when I didn't know anything* (P3).

The dream element in relation to supervision was that the supervisor understood the unique experiences of working rural and remotely as well as an understanding of their unique role.

> *I didn't find it very beneficial because a lot of it was me explaining how the service worked… so I canned that and found another supervisor and she's actually worked out here before... in the same role…so she knows…the challenges and stuff.* (P4)

Theme 3: Acknowledging their role in the client's development of resilience.

As part of exploring the participants' experience of resilience the participants were asked if they experienced compassion satisfaction or vicarious resilience in their role. In asking this question the PI assumed that these concepts would be understood by the participants. However, while the participants were able to talk about the positive feelings associated with acknowledging their role in the client's development of resilience, they were not familiar with the terms compassion satisfaction or vicarious resilience. To help exploring these concepts, the participants were first asked questions about compassion fatigue and vicarious trauma, concepts that they were more familiar with. The participants were able to provide examples of compassion fatigue and vicarious trauma. They talked about loss of compassion, their cup being full, and the impact of taking on clients' stories.

> *…compassion fatigue for me means that in the work that we do that you kind of lose compassion … because … we're forever giving um compassion to the people that we … work with and vicarious trauma is kind of living the trauma of the people that we're, we're working with. So taking on um a lot of their trauma and kind of internalising it* (P7).

While participants talked about the impact of being exposed to their client's trauma experiences, they also identified that organisational demands had a more negative impact. Participants expressed that the system made them feel helpless and that their role was to help the system to help the client. This is consistent with the experience of burnout as expressed in other studies (Hernandez-Wolfe et al 2014, Figley 1995).

It was then explained to the participants that the experiences of burnout, compassion fatigue and vicarious trauma can be mitigated by acknowledging their role in the client's development of resilience, referred to compassion satisfaction (CS) or vicarious resilience (VR), (Figley 1995). The participants understood the idea of resilience, with some saying that they felt that the role had helped them build resilience.

> *Sometimes things don't change for people and horrible things happen. Um but I do think kind of this work has made me generally more resilient because it puts things in perspective* (P2).

When the terms CS and VR were explained the participants were able to provide examples such as setting and achieving goals, being part of the client's development of resilience, and connecting with clients.

> *…not so much the compassion…satisfaction. I haven't really heard much about that, but the vicarious resilience yeah. I definitely think that's a thing* (P4).

> *Yeah I just didn't know what it was called. I thought that I was just happy for them* (P5).

> *So I think I know what compassion satisfaction is, that you feel good about what you do and that you are helping people. I definitely have…experienced that, definitely* (P3).

Most of the participants became excited by the concept and wanted to explore it further, others felt that they were already doing this. Some felt confident that they were able to celebrate their role in their client's improved situation, while the others said that they struggled with this.

> *I think I am good at recognising what I have done…only because like we set goals at the start and I'm constantly referring back to them to make sure that the therapies that I am doing or the techniques that I'm giving then are working towards that goal….I think that I experience that (compassion satisfaction) more than the vicarious trauma side of things or the compassion fatigue side of things and I don't know why but yeah,* (P4).

> *…we're very good at saying well that's the client's journey, and not maybe not acknowledging how much of it is part of the counselling journey as well…And we don't want to take any ownership of the clients story as our own so we're very good at um discounting our contribution to it maybe… and yet sometimes and yet we identify that that's the things that keep us going at the same time… So we probably do need to celebrate it more and particularly support our peers and new staff to...to know how to identify those lightbulb moments, how to celebrate them, how to um keep them close with you when...when its many weeks between that and the next one* (P3).

Some of the participants felt that they would like to explore compassion satisfaction and vicarious resilience further and that this should be an important part of their professional development.

> *….I'll probably be thinking about it for my next supervision to kind of take that time to kind of reflect on some of that positive stuff instead of kind of you know that stuff that I am struggling with or the stuff that I kind of want to talk about and a give a different opinion on. So um yeah thank you* (P7).

Discussion and implications

It was interesting that the participants did not have a good understanding of the concepts of compassion fatigue and compassion satisfaction, especially given that the terms are explained in the ProQOL (Stamm 2010) scale that they have been invited to complete as part of their professional development. However, Stamm (2010) acknowledges that the definitions are confusing with studies in this field tending to focus on the problems associated with defining these terms (Stamm 2010). This may be why the participants struggled to define them during the interviews. An understanding of these concepts developed for the writer throughout the course of this study. It is beyond the scope of this paper to explore the complexities of these terms, however essentially, they describe slightly different aspects of the same concept.

Stamm (2010) suggests that the term compassion fatigue (CF) be used as an umbrella term with burnout, and secondary trauma (also referred to vicarious trauma) as secondary elements (Stamm 2010). CF refers to the natural emotional response of knowing about a traumatic event experienced by someone else (Figley 1995, Conrad & Kellar-Guenther 2006). Vicarious trauma also refers to the potential outcome of working with someone who has experienced trauma (Hernandez-Wolfe, et al 2014). Burnout is the impact of balancing the often competing organisational demands of with the needs of the client (Figley 1995). Burnout differs to CF in that it tends to develop gradually and be brought on by emotional exhaustion, while CF tends to develop suddenly without warning (Figley 1995). Burnout is an important consideration when looking at retention of workers as it is a contributing factor to high staff turnover (Conrad & Kellar-Guenther 2006). In this study some of the participants indicated that organisational demands had a greater impact on them than exposure to their client's stories. This indicates that they may be more susceptible to burnout than compassion fatigue however this requires further exploration that is beyond the scope of this research study.

Compassion satisfaction (CS) can be defined as the combination of positive feelings of helping others through interacting with them, alongside feeling good about being able to participate in bigger picture activities (Stamm 2010). As vicarious resilience (VR) refers to being exposed to another person's development of resilience (McFadden, et al 2014) it can be seen as an element of CS. VR is about the interaction between client and worker and acknowledges the role that they both play in the client's development of resilience (Hernandez- Wolfe et al 2014). Through this interaction the worker learns new ways to deal with their own personal challenges (Hernandez- Wolfe et al 2014). VR can also help build resilience and strategies, to help with stresses associated with working within the organisation (burnout) (Hernandez- Wolfe et al 2014). The participants in the study were able identify the experience of CS and VR , and expressed a desire to understand the concepts better. Greater clarity of these concepts within the literature will help workers to integrate these concepts into their reflective practice. The findings of this study contribute to this ongoing discussion.

The participants in this study were able to demonstrate resilience strategies within their unique situation. These strategies were intentional, and the associated challenges were acknowledged. The resilience strategies included both aspects of CS, being positive feelings of helping other people. and taking part in bigger picture activities. The premise of this study is that these strategies can be generalised to other health professionals in similar circumstances. In rural and remote situations, other allied health professions such as dietetics and occupational therapist may also experience the interwoven issues of being a rural sole practitioner alongside being exposed to vicarious trauma due to having a greater connection to the community. The findings of this study can also be generalised to health workers outside of the rural and remote context who also have the potential to be exposed to vicarious trauma. For example health workers engaging with people who have experienced domestic violence have the potential to develop compassion fatigue and vicarious trauma and therefore need to be provided with

the skills to develop compassion satisfaction and vicarious resilience. This was identified in the NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026 (New South Wales Ministry of Health, 2021) which acknowledges the importance of considering the; *challenges of engaging in work with domestic and family violence, including the impacts of vicarious trauma and support to increase vicarious resilience* (New South Wales Ministry of Health, Forthcoming P44).

This study also provides relevant information to rural and remote recruitment which is a priority concern for NSW Health as evidenced by the inclusion of the issue in both the NSW Rural Health Plan: Towards 2012, and the Health Professionals Workforce Plan (2012-2022 Revised Plan). The strategies outlined by the practitioners in this study may also be helpful to new practitioners to the role as studies suggest that newer trauma counsellors are more likely to experience burnout compared to more experienced counsellors (Ackerley, et al 1988 cited by Pearlman & Mac Ian 1995).

While the participants in this study were able to demonstrate good skills in developing resilience, they also acknowledged that they need to be supported in this by their managers. This included supporting access to face-to-face interactions with their team through professional development opportunities and allowing for time to develop connections. This will become even more important as the reliance on virtual training has grown over recent years especially in response to COVID -19 restrictions. Management needs to understand the specific requirements of sole practitioner counsellors. and support them to spend time developing connections with other workers. and to take part in bigger picture opportunities. Sole practitioners also need to be supported to access supervision that understands their unique circumstances and their specific roles.

Strengths and Limitations

This study gave a voice to a group of professionals who, due to their small number are often overlooked, and their roles poorly understood. However, as only 7 out 19 counsellors participated, there is the potential that only those who felt positive about their roles took part with those who felt less positive not wanting to be involved. The result maybe that the positive outlook of the participants may be overstated in the results. As the PI was a peer of the potential participants and was careful to avoid coercion about participation, this impacted on recruitment as the potential participants could not be approached directly. However, as data saturation was achieved, this impact would be minimal. There were also vacancies and people left the roles during the recruitment stage which reduced the number of potential participants, which is reflective of the overall recruitment/ retention problems in rural and remote areas. Other allied health professionals working rural and remotely may experience the same challenges and follow up studies broadening out to other allied health professionals in similar situation may contribute further to the understanding of resilience.

Conclusion and recommendations

Working in remote and rural towns has challenges. This is particularly the case for those working in counselling roles as sole practitioners due to the inter-woven impact of these challenges with the exposure to their client's trauma. The participants in this study were able to demonstrate they addressed these challenges with intention. They actively developed connections to counter professional isolation. They engaged in self-care that involved taking part in bigger picture activities. They also understood the importance of acknowledging their role in their client's development of resilience. In taking part in this study, they increased their understanding of the concepts of compassion fatigue and compassion satisfaction. The finding of this study can help to inform policy and practice in relation to providing support

with the aim of retention to these roles. The findings from this study can be generalised across other professionals working with people who have experienced trauma.

Recommendations

1. Western NSW Local Area Health District (WNSWLHD) Senior Manager Child Protection, Domestic Violence and Family Violence and Community Health Managers support practitioners to develop professional connections both within their community and within their workplace this includes taking part in bigger picture activities such as working parties, projects, supervising students and face to face professional development opportunities.

2. Community Health Managers to have a better understanding of the role of PARVAN counsellors and their unique professional development needs. Approval to attend professional development opportunities needs to be consistent across sites.

3. Counsellors working in remote and rural areas need to have access to providers of professional supervision who understand both the specific role of the counsellor and the challenges of rural and remote work.

4. Current PARVAN review of professional supervision to include looking at how compassion satisfaction and vicarious trauma can be included in supervision.

5. The findings from this study be used to inform implementation of worker recruitment and retention policies such as NSW Rural Health Plan: Towards 2012, and the Health Professionals Workforce Plan (2012-2022 Revised Plan).

6. The findings from this study be used to contribute to the implementation of supporting workers to develop vicarious resilience as per NSW Health Strategy for Preventing and Responding to Domestic and Family Violence 2021-2026, Strategic Direction Three, priority 3.4: Support the workforce and build resilience.

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Appendices

Appendix 1: Demographic table

Category	Number
Age:	
25-34	2
35-44	2
45-54	2
Not stated	1
Role	
Student	2
Sexual Assault Counsellor	2
Child Protection Counsellor	2
Domestic Violence worker	1
Time in the Role	
< 4 months	3
2years	1
4 years	1
5.5 years	2
Professional Qualifications (most recent) and year qualified	
Bachelor Health Science 2015	1
Master of Social Work student 2020	2
Bachelor Social Work 2003	1
Masters Psychology 2010	1
Master of Social Work	1
Not stated	1
Rural, Remote and Metropolitan Area (RRMA) classification	
RRMA 7	3
RRMA 5	4

Appendix 2: Semi-structured Interview Questions

1. Can you tell me about the circumstances around you working in your current position?

2. What is challenging about working in rural or remote areas and what things have you done to help you cope with these challenges?

3. In what ways have you developed resilience through your experience in this role?

4. Do you experience compassion satisfaction or vicarious resilience in your role?

5. What would the ideal support system for people in situations like yours look like?